

DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

Amendments to Chapter 12-15
Hawaii Administrative Rules
Workers' Compensation
Medical Fee Schedule

December 20, 2004

1. Section 12-15-1, Hawaii Administrative Rules, is amended by adding two new definitions to read as follows:

"Emergency medical services" means initiating all basic life support care as well as invasive patient care designed to stabilize and support a patient's condition due to sudden illness or injury within the first seventy-two hours after date injury.

"Evidence based" means the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual injured employees entitled to benefits. [Eff 1/1/96;

am] (Auth: HRS §§386-21, 386-26, 386-27, 386-72) (Imp: HRS §§386-1, 386-2, 386-21, 386-23, 386-27)

2. Section 12-15-30, Hawaii Administrative Rules, is amended by amending subsection (d) to read as follows:

"(d) Frequency of treatment specified in the rules herein are guidelines to improve provider of service accountability and are [not] intended to be [an] the [authoritative] presumptive prescription for health care[.], subject to the provisions of §12-15-32." [Eff 1/1/96; am] (Auth: HRS §§386-26, 386-27, 386-72) (Imp: HRS §§386-21, 386-26, 386-27, 386-94, 386-96)

3. Section 12-15-31, Hawaii Administrative Rules, is amended by amending subsection (c) to read as follows:

"(c) Any service performed by a provider of service who is not a physician as defined in section 386-1, HRS, shall be referred by and be under the direction of the attending physician. [Treatment may be rendered on the basis of a written prescription and treatment plan approved by the attending physician as specified in section 12-15-34. The prescription and treatment plan shall be individualized for the patient's industrial injury.] All treatment and prescription shall be in writing and in accordance with §12-15-30 and §12-15-32." [Eff 1/1/96; am] (Auth: HRS §§386-21, 386-26, 386-27, 386-72) (Imp: HRS §§386-21, 386-26, 386-27)

4. Section 12-15-32, Hawaii Administrative Rules, is amended to read as follows:

"§12-15-32 [Physicians.] Providers of service.
(a) [Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery requires. Authorization is not required for the initial fifteen treatments of the injury during the first sixty calendar days.] Frequency and extent of treatment shall be in accordance with the ODG Treatment in Workers' Comp, 3rd Edition, issued by the Work Loss Data Institute. In addition to the ODG Treatment in Workers' Comp, 3rd Edition, the director references Chapters 1-7 of the practice guides issued by the American College of Occupational and Environmental Medicine, 2nd Edition, as an expression of disability management philosophy that should be an integral part of practice within the workers' compensation system, and as an educational tool for health care providers and other participants practicing in the workers' compensation system. The treatment guidelines adopted in this subsection are presumed medically necessary and correct. The presumption is rebuttable and may be contested by a preponderance of the scientific medical evidence establishing that a variance from the

guidelines is reasonably required to cure and relieve the employee from the effects of the injury condition.

The attending physician, in addition to submitting the initial report, in accordance with section 386-96, HRS, shall submit on a form prescribed by and to be obtained from the department, entitled "Restorative Services Plan." The "Restorative Services Plan" shall include the following:

- (1) Physical or mental functions necessary to perform job duties;
- (2) Identify the functional deficits caused by the injury;
- (3) Identify the minimal functional level to be attained in order to return to work;
- (4) Provide a treatment protocol;
- (5) Provide a timeline for treatment outcome; and
- (6) Other pertinent information.

(b) [If the physician believes treatments in addition to that allowed by subsection (a) are required, the physician shall mail a treatment plan to the employer under separate cover at least seven calendar days prior to the start of the additional treatments. A treatment plan shall be for one hundred twenty calendar days and shall not exceed fifteen treatments within that period. Treatments provided with less than seven calendar days notice are not authorized. A complete treatment plan shall contain the following elements:

- (1) Projected commencement and termination dates of treatment;
- (2) A clear statement as to the impression or diagnosis;
- (3) A specific time schedule of measurable objectives to include baseline measurements at the start of the treatment plan and projected goals by the end of the treatment plan;
- (4) Number and frequency of treatments;
- (5) Modalities and procedures to be used; and
- (6) An estimated total cost of services.

Treatment plans which do not include the above specified elements but which are reasonable and necessary may not be denied by the employer, but upon written notification from the employer, the physician shall correct the deficiency(s) and the employer's liability is deferred as long as the treatment plan remains deficient. Neither the injured employee nor the employer shall be liable for services provided under a treatment plan that remains deficient. Both the front page of the treatment plan and the envelope in which the plan is mailed shall be clearly identified as a "WORKERS' COMPENSATION TREATMENT PLAN" in capital letters and in no less than ten point type.] For all injuries not covered by the ODG Treatment in Workers' Comp, 3rd Edition, or in cases in which the attending physician believes that additional treatments beyond that provided by subsection (a) are necessary or that a treatment guideline different than that specified in subsection (a) is necessary, the attending physician shall mail a treatment plan to the employer at least fourteen calendar days prior to the start of the additional or differing treatments. The treatment plan shall detail:

- (1) The attending physician's explanation for deviation from the guidelines established under §12-15-32(a), and that the plan is based upon evidence-based medical treatment guidelines generally recognized by the national medical community and that is scientifically based;
- (2) That the proposed treatment plan and guidelines were developed by physicians, with involvement of actively practicing health care providers and are peer-reviewed;
- (3) Projected commencement and termination dates of treatment;
- (4) A clear statement as to the impression or diagnosis;
- (5) Number and frequency of treatments;
- (6) Modalities and procedures to be used;
and
- (7) An estimated total cost of services.

No treatment plan shall be valid that is not based upon evidence-based medical treatment guidelines generally recognized by the national medical community and that is scientifically based. With the exception of emergency medical services, any provider of services who exceeds the treatment guidelines without proper authorization shall be denied compensation for the unauthorized services. Unless agreed by the employee, disallowed fees shall not be charged to the injured employee.

(c) The employer may file an objection to the treatment guideline or proposed treatment plan with documentary evidence supporting the denial and a copy of the denied treatment plan with the director, copying the attending physician and the injured employee. Both the front page of the denial and the envelope in which the denial is filed shall be clearly identified as a "TREATMENT PLAN DENIAL" in capital letters [and in no less than ten point type]. The employer shall be responsible for payment for treatments provided under a complete treatment plan until the date the objection is filed with the director. Furthermore, the employer's objection letter must explicitly state that if the attending physician or the injured employee does not agree with the denial, they may request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial, and failure to do so shall be construed as acceptance of the employer's denial.

In denying medical treatment, the employer must disclose to the attending physician and employee the medically, evidenced-based criteria used as the basis of the objection.

(d) The attending physician or the injured employee may request in writing that the director review the employer's denial of the treatment plan. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. A copy of the denied treatment plan shall be submitted with the request for review. Both the front page of the request for review and the envelope in which the request is filed shall be clearly identified as a "REQUEST FOR REVIEW OF TREATMENT PLAN DENIAL" in

capital letters [and in no less than ten point type]. For cases not under the jurisdiction of the director at the time of the request, the injured employee shall be responsible to have the case remanded to the director's jurisdiction. Failure to file a request for review of the employer's denial with the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial. The recommended guidelines set forth in the ODG Treatment in Workers' Comp, 3rd Edition, and American College of Occupational and Environmental Medicine's Occupational Medicine Practice Guidelines, 2nd Edition, shall be presumptively correct on the issue of extent and scope of medical treatment and utilization, regardless of date of injury. The presumption is rebuttable and may be contested by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure and relieve the employee from the effects of the injury condition.

(e) The director shall issue a decision, after a hearing, either requiring the employer to pay the physician within thirty-one calendar days in accordance with the medical fee schedule if the treatments are determined to be [reasonable and necessary or disallowing the fees for treatments determined to be unreasonable or unnecessary. Disallowed fees shall not be charged to the injured employee.] based upon evidence-based medical treatment guidelines generally recognized by the national medical community and that is scientifically based. In determining the treatment for the claimant, the director will give deference to amendments to the ODG Treatment in Workers' Comp, 3rd Edition, provided the amendments are based on sound scientifically based criteria. Disallowed fees shall not be charged to the injured employee.

(f) [The decision issued pursuant to subsection (e) shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.] For treatments and services by providers of service other than physicians, treatment shall be in accordance with subsection (a) and (b) of this section.

(g) The psychiatric evaluation or psychological testing with the resultant reports shall be limited to

four hours unless the physician submits prior documentation indicating the necessity for more time and receives pre-authorization from the employer. Fees shall be calculated on an hourly basis as allowed under Medicare.

(h) For physical medicine, treatments may include up to four procedures, up to four modalities, or a combination of up to four procedures and modalities, and the visit shall not exceed sixty minutes per injury. When treating more than one injury, treatments may include up to six procedures, up to six modalities, or a combination of up to six procedures and modalities, and the entire visit shall not exceed ninety minutes.

(i) Any [physician] provider of service who exceeds the treatment guidelines without proper authorization shall not be compensated for the unauthorized services.

(j) No compensation shall be allowed for preparing treatment plans and written justification for treatments which exceed the guidelines.

(k) Failure to comply with the requirements in this section may result in denial of fees.

(l) Treatment, prescribed on an in-patient basis in a licensed acute care hospital where the injured employee's level of care is medically appropriate for an acute setting as determined by community standards, are excluded from the frequency of treatment guidelines specified herein." [Eff 1/1/96; am 1/1/97; am] (Auth: HRS §§386-21, 386-26, 386-72) (Imp: HRS §§386-21, 386-26, 386-27)

5. Section 12-15-34, Hawaii Administrative Rules, is repealed.

["§12-15-34 Providers of service other than physicians.

(a) Frequency and extent of treatment shall not be more than the nature of the injury and the process of a recovery require. Any health care treatment or service performed by a Hawaii licensed or certified provider of service other than a physician shall be directed by the attending physician based on a written prescription signed, dated, and approved by the attending physician.

The prescription may authorize up to an initial fifteen treatments of the injury during the first sixty calendar days. For therapists, the prescription may authorize up to an initial twenty treatments of the injury during the first sixty calendar days.

(b) If the attending physician believes treatments in addition to that allowed by subsection (a) are required, the provider of service other than a physician, in lieu of the attending physician, may mail a treatment plan for review and approval to the attending physician who shall, after approval, mail the treatment plan to the employer under separate cover at least seven calendar days prior to the start of the additional treatments. A treatment plan shall be for one hundred twenty calendar days and shall not exceed fifteen treatments within that period. Treatments provided with less than seven calendar days notice are not authorized. A complete treatment plan shall contain the following elements:

- (1) Projected commencement and termination dates of treatment;
- (2) A clear statement as to the impression or diagnosis;
- (3) A specific time schedule of measurable objectives to include baseline measurements at the start of the treatment plan and projected goals by the end of the treatment plan;
- (4) Number and frequency of treatments;
- (5) Modalities and procedures to be used;
and
- (6) An estimated total cost of services.

Treatment plans which do not include the above specified elements but which are reasonable and necessary may not be denied by the employer, but upon written notification from the employer, the physician or the provider of service, with approval by the attending physician, shall correct the deficiency(s) and the employer's liability is deferred as long as the treatment plan remains deficient. Neither the injured employee nor the employer shall be liable for services provided under a treatment plan that remains deficient. Both the front page of the treatment plan and the envelope in which the plan is mailed shall be clearly

identified as a "WORKERS' COMPENSATION TREATMENT PLAN" in capital letters and in no less than ten point type.

(c) The employer may file an objection to the treatment plan with documentary evidence supporting the denial and a copy of the denied treatment plan with the director, copying the attending physician, the provider of service and the injured employee. Both the front page of the denial and the envelope in which the denial is filed shall be clearly identified as a "TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. The employer shall be responsible for payment for treatments provided under a complete treatment plan until the date the objection is filed with the director. Furthermore, the employer's objection letter must explicitly state that if the attending physician or the injured employee does not agree with the denial, they may request a review by the director of the employer's denial within fourteen calendar days after postmark of the employer's denial, and failure to do so shall be construed as acceptance of the employer's denial.

(d) The attending physician or the injured employee may request in writing that the director review the employer's denial of the treatment plan. The request for review shall be filed with the director, copying the employer, within fourteen calendar days after postmark of the employer's denial. A copy of the denied treatment plan shall be submitted with the request for review. Both the front page of the request for review and the envelope in which the request is filed shall be clearly identified as a "REQUEST FOR REVIEW OF TREATMENT PLAN DENIAL" in capital letters and in no less than ten point type. For cases not under the jurisdiction of the director at the time of the request, the injured employee shall be responsible to have the case remanded to the director's jurisdiction. Failure to file a request for review of the employer's denial with the director within fourteen calendar days after postmark of the employer's denial shall be deemed acceptance of the employer's denial.

(e) The director shall issue a decision, after a hearing, either requiring the employer to pay the provider of service other than a physician within thirty-one calendar days in accordance with the medical

fee schedule if the treatments are determined to be reasonable and necessary or disallowing the fees for treatments determined to be unreasonable or unnecessary. Disallowed fees shall not be charged to the injured employee.

(f) The decision issued pursuant to subsection (e) shall be final unless appealed pursuant to section 386-87, HRS. The appeal shall not stay the director's decision.

(g) The provider of service other than a physician shall submit reports at least monthly to the attending physician and employer regarding an injured employee's progress. The preparation and submission of written reports or progress notes to the employer by the provider of service other than a physician are an integral part of the service fee.

(h) Treatments may include up to four procedures, up to four modalities, or a combination of up to four procedures and modalities, and the visit shall not exceed sixty minutes per injury. When treating more than one injury, treatments may include up to six procedures, up to six modalities, or a combination of up to six procedures and modalities, and the entire visit shall not exceed ninety minutes. This section applies to providers of service other than physicians including physical therapists, occupational therapists, massage therapists, and acupuncturists.

(i) Any provider of service other than a physician who exceeds the treatment guidelines without proper authorization shall not be compensated for the unauthorized services.

(j) No compensation shall be allowed for preparing treatment plans and written justification for treatments which exceed the guidelines.

(k) Failure to comply with the requirements in this section may result in denial of fees.

(l) Therapy by physical therapists and occupational therapists, prescribed on an in-patient basis in a licensed acute care hospital where the injured employee's level of care is medically appropriate for an acute setting as determined by community standards or, prescribed on an out-patient post-surgery basis not to exceed thirty calendar days, are excluded from the frequency of treatment guidelines

specified herein."] [Eff 1/1/96; am 1/1/97; R
]

6. Section 12-15-50, Hawaii Administrative Rules, is amended by amending subsection (c) to read as follows:

"(c) Treatment which must be performed immediately or within [fourteen calendar days] seventy-two hours from the end of the workday shift on the date of injury because the condition is life-threatening or could cause serious harm is considered emergency treatment; however, the first treatment of the injury shall be allowed at a hospital based emergency room. This exception does not include "repeat" visits unless an emergency situation exists. The attending physician shall notify the director and the employer as soon as possible when emergency treatment is required." [Eff 1/1/96; am] (Auth: HRS §§386-26, 386-72) (Imp: HRS §§386-21, 386-26, 386-27)

7. Section 12-15-85, Hawaii Administrative Rules, is amended by amending subsection (h) to read as follows:

"(h) Each provider of service shall certify on the bill or charges that such charges are in accordance with chapter 386 HRS, and any related rules. A provider's billing shall be deemed as "certified" under any of the following criteria:

- (1) The official billing is on the provider's official letterhead or billing stationary;
- (2) The official billing is accompanied by a signed statement from the provider attesting that the billing is in conformance with Chapter 386, HRS; or
- (3) The official billing contains the signature of the provider." [Eff 1/1/96; am] (Auth: HRS §§386-21, 386-72) (Imp: HRS §§386-21)

8. Section 12-15-94, Hawaii Administrative Rules, is amended to read as follows:

§12-15-94 Payment by employer. (a) The employer shall pay for all medical services which the nature of the compensable injury and the process of recovery require. The employer is not required to pay for care unrelated to the compensable injury.

(b) When a provider of service notifies or bills an employer, the employer shall inform the provider within sixty calendar days of such notification or billing should the employer controvert the claim for services. Failure of the employer to notify the provider of service shall make the employer liable for services rendered until the provider is informed the employer controverts additional services.

(c) The employer, after accepting liability, shall pay all charges billed within sixty calendar days of receipt of such charges except for items where there is a reasonable disagreement. If more than sixty calendar days lapse between the employer's receipt of an undisputed billing and date of payment, payment of billing shall be increased by one per cent per month of the outstanding balance. In the event of disagreement, the employer shall pay for all acknowledged charges and shall notify the provider of service, copying the claimant, of the denial of payment and the reason for denial of payment within sixty calendar days of receipt. Furthermore, the employer's denial must explicitly state that if the provider of service does not agree, the provider of service may file a "BILL DISPUTE REQUEST" to include a copy of the original bill with the director within sixty calendar days after postmark of the employer's objection, and failure to do so shall be construed as acceptance of the employer's denial.

(d) Employer is authorized to reduce that amount payable to the provider by up to one dollar per line item if the charge is not in compliance with the medical fee schedule.

~~[(d)]~~(e) In the event a reasonable disagreement relating to specific charges cannot be resolved, the employer or provider of service may request intervention by the director in writing with notice to the other party. Both the front page of the billing dispute request and the envelope in which the request is mailed shall be clearly identified as a "BILLING

DISPUTE REQUEST" in capital letters [and in no less than ten point type]. The director shall send the parties a notice and the parties shall negotiate during the thirty-one calendar days following the date of the notice from the director. If the parties fail to come to an agreement during the thirty-one calendar days, then within fourteen calendar days following the thirty-one day negotiating period, either party may file a request, in writing, to the director to review the dispute with notice to the other party. The director shall send the parties a second notice requesting the parties file position statements, with substantiating documentation to specifically include the amount in dispute and a description of actions taken to resolve the dispute, within fourteen calendar days following the date of the second notice from the director. The director shall review the positions of both parties and render an administrative decision without hearing. A service fee of up to \$500 payable to the State of Hawaii General Fund will be assessed at the discretion of the director against either or both parties who fail to negotiate in good faith. The decision of the director is final and not appealable. [Eff 1/1/96; am 12/17/01; am] (Auth: HRS §§386-21, 386-26, 386-71, 386-72) (Imp: HRS §§386-21, 386-26)

9. Material, except source notes, to be repealed is bracketed. New material is underscored.

10. Additions to update source notes to reflect these amendments are not underscored.

11. These amendments to Title 12, Chapter 15, Hawaii Administrative Rules, relating to the Hawaii Workers' Compensation Medical Fee Schedule shall take effect ten days after filing with the Office of the Lieutenant Governor.

I certify that the foregoing are copies of the rules drafted in the Ramseyer format, pursuant to the requirements of section 91-4.1, Hawaii Revised Statutes, which were adopted on () and filed with the Office of the Lieutenant Governor.

Director

APPROVED AS TO FORM:

Deputy Attorney General